PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2004-D35

PROVIDER –
Harborside Healthcare – Indianapolis (formerly Stone Manor Convalescent Center) Indianapolis, Indiana

Provider No. 15-5383

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/ AdminaStar Federal, Inc.

DATE OF HEARING -
February 25, 2004

Cost Reporting Periods Ended
December 31, 1992
December 31, 1993

CASE NOs. 96-0059 & 96-0060

INDEX

ISSUE:

Was the Provider entitled to an exemption from the routine cost limit as a "new provider"?

STATEMENT OF CASE AND PROCEDURAL HISTORY:

Harborside Healthcare – Indianapolis, (Provider), formerly Stone Manor Convalescent Center, is a Medicare skilled nursing facility (SNF) located in Indianapolis, Indiana. This dispute arises from a denial of the Provider's request for higher Medicare payments as a "new provider" of health care services.

The Medicare Program's audit and payment functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and the interpretative guidelines published by the Centers for Medicare and Medicaid Services (CMS).[1]

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports, determines the total amount of Medicare reimbursement due the provider, and notifies the provider in a notice of program reimbursement (NPR). A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. § 405.1835.

The sole issue in dispute in this appeal is whether the Provider is entitled to a new provider exemption under 42 C.F.R. §413.30(e) of the Medicare regulations. Section 1819(a)(1) of the Social Security Act defines a SNF as an institution engaged in providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) establishes the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. Such limitations are addressed in §§1861(v)(7)(B) and 1886(a) of the Social Security Act. 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and also provides an exemption to the limits for "New Providers" at 42 C.F.R. §413.30(e)(2). It states:

> . . . New provider. The Provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

[1] Formerly known as Health Care Financing Administration (HCFA)

On June 1, 1974 the Provider began participating in the Indiana Medicaid program as an intermediate care facility (ICF). Under Indiana's two-tiered reimbursement system, a nursing home could participate in the Medicaid program as an ICF, an SNF or both, and separate per diem reimbursement rates were established based on the level of care provided. Following its certification to participate in the Medicare program on July 24, 1991, the Provider began participating in the Medicaid program as a SNF as well. Accordingly, the Medicaid intermediary established a separate skilled reimbursement rate for the SNF.

The Provider requested an exemption from the Medicare SNF routine cost limits by letter dated March 8, 1994. By letter dated May 16, l994, AdminiStar Federal (Intermediary) recommended granting the exemption. On August 10, 1994, the Provider submitted documentation, prepared by its Director of Nursing, in support of its request for an exemption. The documentation indicated that the date the institution first performed any of the skilled nursing and related services or rehabilitative services found in 42 C.F.R. §409(a), (b), or (c), taking into consideration the operation of the institution under both past and present ownership, was June 1, 1974. Because the Provider was certified to participate in the Medicaid program, the Centers for Medicare and Medicaid Services was able to validate this documentation by utilizing data found in its On-Line Survey Certification Reporting System (OSCAR) to determine if, in fact, the supporting documentation provided by the Provider with its request was accurate. CMS was able to validate that the Provider had provided skilled nursing and related services and rehabilitative services since June 24, 1988.

The OSCAR data was collected from the Residents Census and Characteristics Report that the Provider submitted to the survey team at the time of the Provider's annual surveys. The dates of the annual surveys wherein data was collected were June 24, 1991, June 21, 1990, June 15, 1989 and June 29, 1988. This data was self-reported by the institution using the February 1986 version of CMS Form 519 and the January 1990 version of CMS Form 672.[2] By letter dated April 14, 1995, AdminiStar Federal advised the Provider that CMS had denied the Provider's request for an exemption from the SNF routine cost limitations.

On May 31, 1995, the Provider resubmitted its exemption request, using new data provided by its Medical Records personnel, and challenged the accuracy of the data that was submitted with its first request, contending that the original Provider Services Survey had been prepared incorrectly.

The amount in dispute for calendar years 1992 and 1993 is $61,000 and $77,000, respectively.

The Provider appealed CMS' determination to the Board and satisfied the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Peter R. Leone, Esquire, of McDermott, Will and Emery. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

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[2] See Intermediary Exhibit I-7 and I-8.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, evidence submitted and parties' contentions, finds and concludes that the Intermediary properly denied the Provider's new provider exemption request.

The regulation at 42 C.F.R. §413.30(e)(2) allows for an exemption from Medicare's limit on reimbursable costs as a "New Provider" if the provider has operated as the type of provider (or its equivalent) for which it is certified for Medicare under present and previous ownership for less than three full years. The timing and type of services (skilled vs. non-skilled) are at issue in this case. The Provider, as part of its original exemption request, submitted a questionnaire signed by its Director of Nursing which substantiated that various skilled nursing services (nine of the ten listed in the questionnaire) had been provided as early as June, 1974.[3] The Intermediary reviewed this documentation, compared it to the services set forth in 42 C.F.R. §409.33(a) – (c), and found the questionnaire to be appropriate and correct. The Board concurs. After CMS rejected the Provider's request,[4] the Provider submitted a letter signed by its Vice-President of Reimbursement recanting the Director of Nursing's statements in the original request.[5] His May 31, 1995 letter stated that he had prepared the first survey due to the Provider's Administrator and Director of Nursing leaving the Provider. He further stated that the revised survey provided appropriate data in a supplemental survey prepared by medical records personnel. The Provider also furnished affidavits regarding: (1) the Intermediary's use of the OSCAR reports[6] and (2) physical therapy, occupational therapy and speech rehabilitation therapy provided from 1988-1990.[7]

The Board finds the supplemental arguments which recanted the original survey results unconvincing. The Board observes that the Provider chose to have a record hearing in this case. Thus, it chose not to provide oral testimony to support its position. The Provider did not develop appropriate analyses to substantiate why the initial survey was inaccurate or inadequate. In fact, the Director of Nursing actually signed the original survey.

The Board further finds that contrary to the Provider's argument, CMS's use of the OSCAR and related documents for 1988-1990 is an appropriate means of establishing the type of services rendered by the Provider. The Intermediary's review of these reports established that skilled nursing services were provided in those periods.

The Board finds that the Provider's request for a new provider exemption does not meet the intent of the Medicare law, which is to provide relief to a new provider for providing services that require a significant amount of related start-up costs. This Provider was primarily furnishing intermediate care services, and it provided skilled care when needed. The conversion

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[3] See Intermediary Exhibit 6.
[4] See Intermediary Exhibit 4.
[5] See Provider Exhibit 12
[6] See Provider Exhibit 38
[7] See Provider Exhibit 39

to a skilled nursing facility required minimal start-up activity since skilled services were already being performed.

The Board concurs with the Intermediary that the Provider incorrectly asserted that an institution that operated as an ICF was prohibited from providing skilled nursing or rehabilitative services. The Board finds that the Medicaid statute and regulations[8] not only permit an ICF to perform skilled services, but if the needs of the patients so require and the services are ordered by a physician, an ICF must, with some limitations, furnish needed skilled services. The Board further finds that the use of the Provider's own records of services furnished is the most convincing evidence of the skilled nature of the services, particularly when those records were created contemporaneously with rendering the services and when the nature of those services was not in issue as it is in this dispute.

DECISION AND ORDER:

The Provider is not eligible to be treated as a "new provider" under 42 C.F.R. §413.30(e)(2). The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: August 19, 2004

FOR THE BOARD:

Suzanne Cochran
Chairman

[8] 42 U.S.C. §1396d(a); 42 C.F.R. §440.40; 42 C.F.R. §§409.31-409.35.